Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Dec 6, 2016	2016_320612_0024	028549-16	Resident Quality Inspection

Licensee/Titulaire de permis

CHAPLEAU HEALTH SERVICES
C/O CHAPLEAU GENERAL HOSPITAL 6 BROOMHEAD ROAD CHAPLEAU ON P0M 1K0

Long-Term Care Home/Foyer de soins de longue durée

THE BIGNUCOLO RESIDENCE
C/O Chapleau General Hospital P. O. Box 757, 6 Broomhead Road CHAPLEAU ON P0M 1K0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

SARAH CHARETTE (612), TIFFANY BOUCHER (543)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): October 18-21, 2016.

During the course of the inspection, the Inspectors also reviewed one Critical Incident (CI) report submitted to the Director by the home related to the fall of a resident, one CI report related to a family complaint about the care provided to a resident and one complaint related to the care provided to a resident.

During the course of the inspection, the inspector(s) spoke with Chief Executive Officer (CEO), Long-Term Care (LTC) Team Leader, Acting Director of Care/Patient Care Manager, Support Services Manager, Resident Assessment Instrument - Minimum Data Set (RAI-MDS) Coordinator, Registered Dietitian (RD), Occupational Therapist (OT), Activation Coordinator, Communication, Risk Management and Patient Safety Coordinator, Clinical Educator, Occupational Health and Infection Control RN, Registered Practical Nurses (RPNs) and residents and their family members.

The Inspector(s) conducted a daily walk through of resident areas, observed the provision of care towards residents, observed staff to residents interactions, reviewed residents' health care records, policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Residents' Council

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **3 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices and if there were none, in accordance with prevailing practices, to minimize the risk to the resident.

During stage one of the Resident Quality Inspection (RQI), Inspector #612 observed resident #002, #003 and #004, with bed rails engaged in the guard position on their bed.

Inspector #612 interviewed the Occupational Therapist (OT) and the Long-Term Care (LTC) Team Lead who stated that the home had evaluated the entrapment zones for one LTC bed which had failed in zone four. The OT and LTC Team Lead stated that they did not continue to test the rest of the entrapment zones on the LTC beds as all the beds were the same type and therefore concluded that zone four would fail on the rest of the beds. The LTC Team Lead stated that most of the residents had the upper two quarter bed rails engaged in the guard position.

The LTC Team Lead confirmed that residents #002 and #003 utilized the specific number of bed rails, engaged in the guard position. They stated that resident #004 did not require bed rails; however, the resident was independent and could possibly raise them and lower them by themselves. Upon review of Point Click Care (PCC), the LTC Team Lead stated that a bed rail assessment was not completed for resident #002, #003 or #004.

The LTC Team Lead stated that the policy related to bed entrapment and bed rail assessments was currently being developed.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August21, 2012, was sent to all Long-Term Care (LTC) Home administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document references the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails.

The CGA document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and an evaluation was needed to assess the relative risk of using the bed rail. The use of bed rails should have been based on a resident's assessed needs, documented clearly and approved by the interdisciplinary team. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During stage one of the Resident Quality Inspection (RQI), Inspector #612 observed resident #002, #003 and #004, with bed rails engaged in the guard position on their bed.

Inspector #612 interviewed the OT and the LTC Team Lead who stated that the home had assessed one LTC bed which had failed in zone four on June 30, 2016. The OT and LTC Team Lead stated that they did not continue to test the rest of the LTC beds as all the beds were the same type and therefore concluded that zone four would fail on the rest of the beds.

The OT stated that an item had been ordered which would extend the bed rail and eliminate the gap which caused zone four to fail. In the meantime, no other actions were taken to reduce the risk of entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for the resident set out the planned care for the resident.

During stage one of the RQI, resident #003 was identified through a staff interview as utilizing a specific device which was identified as a restraint.

Inspector #612 reviewed the documentation in Point Of Care (POC) which identified the device as a restraint for resident #002 and #003.

Inspector #612 reviewed resident #002 and #003's most recent care plans and was unable to find a focus related to the device or restraints.

Inspector #612 reviewed resident #002 and #003's most recent care plan with the LTC Team Lead who confirmed that the care plan should have contained a focus related to the use of the device or restraints. Upon review of resident #002 and #003's care plan, they were unable to find any focus related to the device or restraints. [s. 6. (1) (a)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

Inspector #543 reviewed a Critical Incident (CI) report that was submitted to the Director, which identified that resident #001 had a fall approximately a week prior, that resulted in an injury.

Inspector #543 reviewed resident #001's care plan, which identified specific interventions related to their mobility.

Inspector #543 interviewed the LTC Team Leader on October 20, 2016, who indicated that resident #001's care needs had changed as a result of the fall identified in the CI report and the plan of care had not been updated to address this. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care sets out the planned care for resident #002 and #003 and that the plan of care for resident #001 and any other resident is reviewed and revised when the resident's care needs change or the care set out in the plan of care is no longer necessary, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, a care conference of the interdisciplinary team providing a resident’s care was held within six weeks following the resident’s admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker.

Inspector #543 reviewed a complaint submitted to the Director in regards to the care provided to resident #001 and communication related to the care of this resident.

During an interview with Inspector #543, the LTC Team Leader indicated that the home held a multidisciplinary care conference for residents six weeks post admission and annually thereafter.

In an interview with RPN #108, they verified that the home would conduct a multidisciplinary care conference for all residents six weeks post admission as well as annually. RPN #108 substantiated that for resident #001 there was no multidisciplinary care conference held six weeks post admission, and verified that the multidisciplinary care conference was held almost six months post admission.

Inspector #543 randomly selected two other residents, to verify that multidisciplinary care conferences were held six weeks post admission. The Inspector reviewed resident #007's health care record, and identified that there was no multidisciplinary care conference held until six months post admission. A review of resident #002's health care record identified that this resident had been in the home for three months and there had not been a multidisciplinary care conference.

The Inspector reviewed resident #001, #002 and #007's health care records with the LTC Team Leader who confirmed that multidisciplinary care conferences had not been held six weeks post admission. [s. 27. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a care conference with the interdisciplinary team providing a resident's care, is held within six weeks following the resident's admission, to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that every use of a physical device to restraint a resident under section 31 of the Act was documented and without limiting the generality of this requirement, the licensee shall ensure that the following was documented: 2. What alternatives were considered and why those alternatives were inappropriate.

During stage one of the RQI, resident #003 was identified through a staff interview as utilizing a specific device which was identified as a restraint.

Inspector #612 reviewed resident #003's health care record and identified that the resident had a physician order written, which indicated that the resident required the device and a consent for the device which was signed by the resident's substitute decision maker. The Inspector reviewed the health care record with the LTC Team Lead and was unable to locate any progress notes or documentation to indicate any alternatives trialed.

Inspector #612 interviewed the LTC Team Lead who stated that specific alternatives were trialed and determined to be ineffective. The LTC Team Lead stated that the alternatives considered and why they were inappropriate should have been included in the restraint assessment; however, they confirmed that it was not documented. [s. 110. (7) 2.]

2. The licensee has failed to ensure that every use of a physical device to restraint a resident under section 31 of the Act was documented and, without limiting the generality of this requirement, the licensee shall ensure that the following was documented: 6. All assessment, reassessment and monitoring, including the resident's response.

During stage one of the RQI, resident #003 was identified through a staff interview as utilizing a specific device which was identified as a restraint.

Inspector #612 reviewed resident #003's health care record and identified that the resident had a physician order written, which indicated that the resident required the use of the device and a consent for the device which was signed by the resident's substitute decision maker. The Inspector reviewed the health care record with the LTC Team Lead and was unable to find any restraint assessment.

The Inspector reviewed the home's policy titled, "Restraint Policy", last reviewed May 26, 2015, which stated that the resident must have had a comprehensive and in-depth assessment prior to the application of a restraint. The assessment was to be completed by the clinical team in collaboration with the resident and/or their substitute decision-maker.

Inspector #612 interviewed the LTC Team Lead who stated that the resident was assessed prior to the application of the device and that should have been documented in a restraint assessment form in Point Click Care (PCC) and it was not done. [s. 110. (7) 6.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every use of a physical device to restrain a resident under section 31 of the Act was documented and without limiting the generality of this requirement, the licensee shall ensure that the following was documented: (2) alternatives that were considered and why they were inappropriate and (6) all assessment, reassessment and monitoring, including the resident's response, to be implemented voluntarily.

Issued on this 7th day of December, 2016

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	SARAH CHARETTE (612), TIFFANY BOUCHER (543)
Inspection No. / No de l'inspection :	2016_320612_0024
Log No. / Registre no:	028549-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Dec 6, 2016
Licensee / Titulaire de permis :	CHAPLEAU HEALTH SERVICES C/O CHAPLEAU GENERAL HOSPITAL, 6 BROOMHEAD ROAD, CHAPLEAU, ON, P0M-1K0
LTC Home / Foyer de SLD :	THE BIGNUCOLO RESIDENCE C/O Chapleau General Hospital, P. O. Box 757, 6 Broomhead Road, CHAPLEAU, ON, P0M-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gail Bignucolo

To CHAPLEAU HEALTH SERVICES, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall:

1. Utilize the Clinical Guidance for the Assessment and implementation of Bed Rails in Hospitals, Long-Term Care Facilities, and Home Care Settings document, to assess the resident for bed rail use;

2. Conduct bed system evaluations for all residents who require the use of bed rails, following the Health Canada guidance document, and re-assess when there is a change in the resident's condition or bed system;

3. Maintain a record of the resident assessment and the bed system evaluation; including, the type of mattresses and beds used for each resident;

4. Update/revise the home's policy related to resident assessment and bed system evaluation with any changes made;

5. Ensure that the plans of care for resident #002, #003, and #004 provide clear direction to all direct care staff.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident

was assessed and his or her bed system evaluated in accordance with evidence-based practices and if there were none, in accordance with prevailing practices, to minimize the risk to the resident.

During stage one of the Resident Quality Inspection (RQI), Inspector #612 observed resident #002, #003 and #004, with bed rails engaged in the guard position on their bed.

Inspector #612 interviewed the Occupational Therapist (OT) and the Long-Term Care (LTC) Team Lead who stated that the home had evaluated the entrapment zones for one LTC bed which had failed in zone four. The OT and LTC Team Lead stated that they did not continue to test the rest of the entrapment zones on the LTC beds as all the beds were the same type and therefore concluded that zone four would fail on the rest of the beds. The LTC Team Lead stated that most of the residents had the upper two quarter bed rails engaged in the guard position.

The LTC Team Lead confirmed that residents #002 and #003 utilized the specific number of bed rails, engaged in the guard position. They stated that resident #004 did not require bed rails; however, the resident was independent and could possibly raise them and lower them by themselves. Upon review of Point Click Care (PCC), the LTC Team Lead stated that a bed rail assessment was not completed for resident #002, #003 or #004.

The LTC Team Lead stated that the policy related to bed entrapment and bed rail assessments was currently being developed.

A memo from the Ministry of Health and Long-Term Care (MOHLTC) dated August 21, 2012, was sent to all Long-Term Care (LTC) Home administrators indicating that all LTC homes should use the Health Canada guidance document 'Adult Hospital beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards' as a best practice document in their homes. This document references the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings' (CGA), as a prevailing practice for the assessing the use of bed rails.

The CGA document indicated that automatic use of bed rails may pose unwarranted hazards to resident safety and an evaluation was needed to assess the relative risk of using the bed rail. The use of bed rails should have been

based on a resident's assessed needs, documented clearly and approved by the interdisciplinary team. (612)

2. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During stage one of the Resident Quality Inspection (RQI), Inspector #612 observed resident #002, #003 and #004, with bed rails engaged in the guard position on their bed.

Inspector #612 interviewed the OT and the LTC Team Lead who stated that the home had assessed one LTC bed which had failed in zone four on June 30, 2016. The OT and LTC Team Lead stated that they did not continue to test the rest of the LTC beds as all the beds were the same type and therefore concluded that zone four would fail on the rest of the beds.

The OT stated that an item had been ordered which would extend the bed rail and eliminate the gap which caused zone four to fail. In the meantime, no other actions were taken to reduce the risk of entrapment.

There was no previous non-compliance related to O. Reg. 79/10 s. 15 (1).

The decision to issue this compliance order was related to the severity, which was a potential for actual harm and the scope, which was wide spread as it affected all residents who used side rails. (612)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 10, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 6th day of December, 2016

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Sarah Charette

Service Area Office /
Bureau régional de services : Sudbury Service Area Office